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BEFORE THE
STATE BOARD OF OPTOMETRY
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **STEPHEN EUGENE FRY** **11 3rd Avenue** **Chula Vista, CA 91910** **Optometrist License No. 6220** Respondent.	Case No. CC 2010-176 **ACCUSATION**

Complainant alleges:

PARTIES

1. Mona Maggio (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the State Board of Optometry, Department of Consumer Affairs.

2. On or about October 3, 1977, the State Board of Optometry issued Optometrist License Number 6220 to Stephen Eugene Fry (Respondent). The Optometrist License expired on December 31, 2011, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the State Board of Optometry (Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 118, subdivision (b), provides:

"The suspension, expiration, or forfeiture by operation of law of a license issued by a board in the department, or its suspension, forfeiture, or cancellation by order of the board or by order of a court of law, or its surrender without the written consent of the board, shall not, during any period in which it may be renewed, restored, reissued, or reinstated, deprive the board of its authority to institute or continue a disciplinary proceeding against the licensee upon any ground provided by law or to enter an order suspending or revoking the license or otherwise taking disciplinary action against the licensee on any such ground."

5. Section 3090 of the Code states:

"Except as otherwise provided by law, the board may take action against all persons guilty of violating this chapter or any of the regulations adopted by the board. The board shall enforce and administer this article as to license holders, and the board shall have all the powers granted in this chapter for these purposes, including, but not limited to, investigating complaints from the public, other licensees, health care facilities, other licensing agencies, or any other source suggesting that an optometrist may be guilty of violating this chapter or any of the regulations adopted by the board."

STATUTORY PROVISIONS

6. Section 136 provides:

(a) Each person holding a license, certificate, registration, permit, or other authority to engage in a profession or occupation issued by a board within the department shall notify the issuing board at its principal office of any change in his or her mailing address within 30 days after the change, unless the board has specified by regulations a shorter time period.

(b) Except as otherwise provided by law, failure of a licentiate to comply with the requirement in subdivision (a) constitutes grounds for the issuance of a citation and administrative fine, if the board has the authority to issue citations and administrative fines.

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7. Section 3007 provides:

An optometrist shall retain a patient's records for a minimum of seven years from the date he or she completes treatment of the patient. If the patient is a minor, the patient's records shall be retained for a minimum of seven years from the date he or she completes treatment of the patient and at least until the patient reaches 19 years of age.

8. Section 3070, subdivision (a), provides, in pertinent part:

(a) Before engaging in the practice of optometry, each licensed optometrist shall notify the board in writing of the address or addresses where he or she is to engage, or intends to engage, in the practice of optometry and, also, of any changes in his or her place of practice. The practice of optometry is the performing or the controlling of any of the acts set forth in Section 3041.

(b) A licensed optometrist is not required to provide the notification described in subdivision (a) if he engages in the temporary practice of optometry in any of the following settings:

(1) A facility licensed by the State Department of Public Health;

(2) A public institution, including, but not limited to, a school, a community college, and federal, state, and local penal and correctional facilities;

(3) A mobile unit that is operated by a governmental agency or by a nonprofit or charitable organization;

(4) The home of a patient who is not ambulatory;

(5) The practice location of another optometrist that has been reported to the Board pursuant to this section if the other optometrist is ill or on a temporary leave or for any other reason approved by the Board. The exception under this paragraph is limited to a total period of all temporary practice locations of seven calendar days during a 30-day period and 84 days during a calendar year.

(c) Notwithstanding Section 3075, an optometrist engaging in the temporary practice of optometry at a location described in subdivision (b) shall carry and present upon demand evidence of his or her licensure but shall not be required to post his or her current license or other evidence of current license status issued by the Board.

(d) In addition to the information required by section 3076, a receipt issued to a patient by an optometrist engaging in the temporary practice of optometry at a location described in subdivision (b) shall contain the address of the optometrist's primary practice location and the temporary practice location where the services were provided.

(e) "Temporary practice" shall be defined by the Board for purposes of this section.

9. Section 3110 provides, in pertinent part:

The board may take action against any licensee who is charged with unprofessional conduct, and may deny an application for a license if the applicant has committed unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly assisting in or abetting the violation of, or conspiring to violate any provision of this chapter or any of the rules and regulations adopted by the board pursuant to this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions.

. . .

(q) The failure to maintain adequate and accurate records relating to the provision of services to his or her patients.

. . .

10. Health and Safety Code section 123145 provides, in pertinent part:

(a) Providers of health services that are licensed pursuant to sections 1205, 1253, 1575, and 1726 have an obligation, if the licensee ceases operation, to preserve records for a minimum of seven years following the discharge of a patient, except that the records of unemancipated minors shall be kept at least one year after the minor has reached the age of 18 years, and in any case, not less than seven years.

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(b) The department or any person injured as a result of the licensee's abandonment of health records may bring an action in a proper court for the amount of damage suffered as a result thereof. In the event that the licensee is a corporation or partnership that has dissolved, the person injured may take action against the corporation's or partnership's principal officers of record at the time of dissolution.

(c) Abandonment means violating subdivision (a) and leaving patients treated by a licensee without access to medical information to which they are entitled pursuant to section 123110.

REGULATORY PROVISIONS

11. California Code of Regulations, title 16, section 1510, provides that inefficiency in the profession is indicated by the failure to use, or the lack of proficiency in the use of the ophthalmoscope, the retinoscope, the ophthalmometer (or keratometer), tonometer, biomicroscope, any one of the modern refracting instruments such as the phoroptor, refractor, etc., or the phorometer-trial frame containing phoria and duction measuring elements or a multicelled trial frame, trial lenses, and prisms, in the conduct of an ocular examination; the failure to make and keep an accurate record of findings; lack of familiarity with, or neglect to use, a tangent screen or perimeter or campimeter; and the failure to make a careful record of the findings when the need of the information these instruments afford is definitely indicated.

COST RECOVERY

12. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

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FACTUAL BACKGROUND

13. On or about February 23, 2011, patient N.L. had an eye examination with Respondent at his place of business. On that date, Patient N.L. purchased a pair of eyeglasses from Respondent for $210.00. On or about March 1, 2011, Patient N.L. received a voicemail message from Respondent's office stating that her glasses were ready to be picked up at Respondent's office. On or about March 3, 2011, Patient N.L. went to Respondent's office to pick up her glasses. Respondent's office was locked with an eviction notice posted on the door.

14. Patient N.L. returned to Respondent's office repeatedly, hoping to find someone there who could deliver her glasses, but the office continued to be closed. Patient N.L. went into the liquor store next door to Respondent's office, and was told that some of Respondent's employees have come into the liquor store. Patient N.L. left her contact information with the liquor store employee, asking him to give it to anyone connected to Respondent who stopped by with the request that they call Patient N.L. in hopes that someone would be able to help her get her glasses.

15. In or about March 2011, after being evicted by the property management company, respondent walked away from his optometry business "DR. S.E. FRY INC.," in Chula Vista, California. Respondent did not notify his patients or the Board that he was closing his business, nor did he leave any contact information at the previous location of his business.

16. On or about December 5, 2011, Respondent was contacted by a Board investigator regarding his patient records and the status of his optometry practice. Respondent admitted he had walked away from his practice early in 2011, after a "rent increase dispute" with the management company. Respondent stated that he is no longer practicing optometry, and does not plan to do so in the future. Respondent stated that he had all of his patient records in storage, and was arranging for his records to be transferred to Dr. E, another optometrist located in Chula Vista.

17. On or about December 5, 2011, Dr. E was contacted by the Board investigator at his practice location in Chula Vista. Dr. E confirmed that he had spoken with Respondent recently about transferring all of Respondent's patient records to Dr. E's office. Dr. E stated that he expected the transfer to happen within the next few weeks.

18. On July 5, 2012, a Board employee contacted Dr. E by telephone to check on the status of the transfer of Respondent's patient records to Dr. E's office. Dr. E stated that he hadn't spoken with Respondent in "about a month or so," and is working with Respondent to have all of the patient records transferred to Dr. E's office. He stated that Respondent had become ill, so he hadn't pressed Respondent for the records.

19. The Board employee reminded Dr. E of the conversation he had with another investigator in December, 2011, wherein Dr. E stated that he expected the records to be transferred within a couple of weeks. Dr. E stated that he had not received any records from Respondent, but that he would "try to find" Respondent's telephone number and call Respondent. Dr. E stated that he would call the investigator back later that day.

20. On or about August 9, 2012, a Board employee contacted Respondent by telephone to check on the status of the transfer of Respondent's patient records to Dr. E. Respondent stated that he had given the storage to Dr. E and that Respondent didn't know what was going on with the records.

21. Respondent was advised that Dr. E didn't know where the records were and stated that he hadn't spoken to Respondent in "some time." Respondent stated he would call Dr. E and the storage unit and find out what was going on with the records. Respondent advised he would call the investigator back by the end of that week.

22. On or about August 16, 2012, the Board requested additional investigation by the Division of Investigation (DOI); specifically requesting that the records of the storage unit used by Respondent be subpoenaed to determine if the patient records were still there and if not, who the storage unit had been sold to.

23. On or about August 29, 2012, a subpoena was served on the storage facility used by Respondent.

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24. Pursuant to the subpoena, it was determined that the unit was not leased by Respondent, but he was listed as an alternate contact on the unit. The unit was leased to "James." Additionally, the contents of the unit were sold on July 5, 2012, to "Carlos." Telephone contact with Carlos revealed that he had sold the contents of the unit to a third party, and he did not look at the contents of the unit before selling it.

25. On September 10, 2012, the investigator telephoned the number provided for James in all of the storage facility paperwork. The number was answered by another party who stated he did not know James.

26. On September 10, 2012, the investigator telephoned the number provided for Carlos on the bill of sale for the contents of the unit. The investigator advised Carlos that he was trying to determine what happened to the patient's records that were in the storage unit he purchased. Carlos again stated that he had never looked inside the unit, and sold it to a third party. Carlos provided the telephone number for the third party buyer of the unit.

27. Between September 10-24, 2012, the investigator made numerous calls to the third party buyer at the number provided by Carlos, leaving numerous messages explaining that the investigator only needed to determine what happened to the documents. No return phone call was received.

FIRST CAUSE FOR DISCIPLINE

(Failure to Notify the Board of Change of Mailing Address)

28. The allegations of paragraphs 13-27 are realleged and incorporated by reference as if fully set forth.

29. Respondent has subjected his license to disciplinary action under Business and Professions Code section 136, subdivision (a), because he failed to notify the Board of a change in his mailing address within 30 days. As set forth above, Respondent failed to notify the Board within 30 days that he had abandoned his office in Chula Vista.

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SECOND CAUSE FOR DISCIPLINE

(Failing to Retain Patient Records)

30. The allegations of paragraphs 13-27 are realleged and incorporated by reference as if fully set forth.

31. Respondent has subjected his license to disciplinary action under Business and Professions Code section 3007, because he failed to retain patient records for seven years or until a minor reaches 19 years of age. As set forth above, the records were sold to an unknown party after being abandoned by Respondent at a storage facility.

THIRD CAUSE FOR DISCIPLINE

(Failing to Notify the Board of a Change of Address)

32. The allegations of paragraphs 13-27 are realleged and incorporated by reference as if fully set forth.

33. Respondent has subjected his license to disciplinary action under Business and Professions Code section 3070, subdivision (a), because he failed to notify the Board of a change in the address of his practice. As set forth above, Respondent failed to notify the Board that he had abandoned his office in Chula Vista.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Gross Negligence)

34 The allegations of paragraphs 13-27 are realleged and incorporated by reference as if fully set forth.

35. Respondent has subjected his license to disciplinary action under Business and Professions Code section 3110 for unprofessional conduct, as defined by section 3110(b). As set forth above, Respondent was grossly negligent by committing acts including, but not limited to, the following: abandoning his practice; failing to inform patients that he closed his practice; failing to provide patients with contact information; failing to establish a procedure for patients to request records, prescriptions, or eyewear previously paid for, or have them transferred to another practitioner; failing to advise patients where their records were stored; failing to respond to patients; failing to maintain proper patient records; abandoning patient files at a storage facility

allowing them to be sold to an unknown third party; and failing to provide patients their records and eyewear.

FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Repeated Negligent Acts)

36. The allegations of paragraphs 13-27 are realleged and incorporated by reference as if fully set forth.

37. Respondent has subjected his license to disciplinary action under Business and Professions Code section 3110 for unprofessional conduct, as defined by section 3110(c). As set forth above, Respondent was repeatedly negligent by committing acts including, but not limited to, the following: abandoning his practice; failing to inform patients that he closed his practice; failing to provide patients with contact information; failing to establish a procedure for patients to request records, prescriptions, or eyewear previously paid for, or have them transferred to another practitioner; failing to advise patients where their records were stored; failing to respond to patients; failing to maintain proper patient records; abandoning patient files at a storage facility allowing them to be sold to an unknown third party; and failing to provide patients their records and eyewear.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Failing to Maintain Adequate and Accurate Records)

38. The allegations of paragraphs 13-27 are realleged and incorporated by reference as if fully set forth.

39. Respondent has subjected his license to disciplinary action under Business and Professions Code section 3110 for unprofessional conduct, as defined by section 3110(q). As set forth above, Respondent failed to maintain adequate and accurate records by abandoning patient records at a storage facility, allowing them to be sold to an unknown third party.

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SEVENTH CAUSE FOR DISCIPLINE

(Professional Inefficiency for Failing to Keep an Accurate Record of Findings)

40. The allegations of paragraphs 13-27 are realleged and incorporated by reference as if fully set forth.

41. Respondent has subjected his license to disciplinary action under California Code of Regulations, title 16, section 1510, for professional inefficiency in failing to keep an accurate record of findings. As set forth above, Respondent failed to keep accurate records of findings because he abandoned patient files at a storage facility allowing them to be sold to an unknown third party.

EIGHTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct-Violation of Rules and Regulations Adopted by the Board)

42. The allegations of paragraphs 13-41 are realleged and incorporated by reference as if fully set forth.

43. Respondent has subjected his license to disciplinary action under Business and Professions Code section 3110 for unprofessional conduct, as defined by section 3110(a). As set forth above, Respondent committed unprofessional conduct by violating rules and regulations adopted by the Board including, but not limited to, the following:

a. Failure to notify the Board of a change in his mailing address within 30 days, in violation of section 136, subdivision(a), as set forth above;

b. Failure to retain patient records for seven years or until a minor reaches 19 years of age, in violation of section 3007, as set forth above;

c. Failure to notify the Board of a change in the address of his practice in violation of section 3070(a), as set forth above;

d. Commission of gross negligence in violation of 3110(b), as set forth above;

e. Commission of repeated negligent acts, in violation of 3110(c), as set forth above;

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f. Failure to maintain adequate and accurate records, in violation of 3110(q), as set forth above; and

g. Commission of professional inefficiency in that he failed to keep an accurate record of findings, in violation of California Code of Regulations, title 16, section 1510, as set forth above.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the State Board of Optometry issue a decision:

1. Revoking or suspending Optometrist License Number 6220, issued to Stephen Eugene Fry;

2. Ordering Stephen Eugene Fry to pay the State Board of Optometry the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: May 9, 2013

MONA MAGGIO
Executive Officer
State Board of Optometry
Department of Consumer Affairs
State of California
Complainant

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